



Healthy Member Rewards Program

Eligibility: Member may receive up to \$75 per year for attending their initial and HIV monitoring visits (Section II), annual reproductive health visit (Section III) and case management assessment (Section IV).

Please complete the below information, including PCP, Specialist or Case Manager signature (Section IV and return to Amida Care via fax (646-786-1837) or mail (248 West 35th Street, 7th flr., New York, NY 10001).

Section I Member Information

Name: _____ CIN#: _____
Address: _____ City: _____ State: _____ Zip _____
Primary Phone:(_____) _____ Other Phone:(_____) _____

Section II Primary Care Provider Initial Assessment (\$10) /Viral Monitoring Visit Information (\$10/quarter)

PCP Name: _____ Site/Facility: _____
Phone: (_____) _____ Fax: (_____) _____
Date of visit: _____

Please check all completed activities below.

- CD4 Result _____ Viral Load Result _____
 Mental Health Screen _____ Substance Abuse Screen _____

F/U PCP visit scheduled for _____

Section III Reproductive Health Annual Visit Information (\$25 /year)

Provider Name: _____ Site/Facility: _____
Phone: (_____) _____ Fax: (_____) _____

- GYN Exam done *Date:* _____ PAP smear done *Date:* _____
 STD Screening done *Date:* _____ Mammogram done *Date:* _____
 Safety/Prevention Issues, including safe sex, discussed

Section IV Case Management Assessment (\$10/ year)

Assessment done *Date:* _____ Agency _____

Section V The above mentioned patient has completed their visit as described

Provider Name (Print): _____

Provider Signature: _____ Date: _____

Please mail or fax (646-786-1837) this form to:

Amida Care Member Services @ 248 West 35th St. 7th flr. New York, NY 10001